AUTHORIZATION FOR PICK-UP

Participant's Name (print):_____Age:_____

Address:_____
Number Street City State Zip

Parent/guardian's Name (print):	Relationship:
Home Phone:	Work Phone:
Parent/guardian's Name (print):	Relationship:
Home Phone:	Work Phone:
Emergency Contact (print):	Relationship:
Home Phone:	Work Phone:
Notes:	

Authorized Person(s) To Pick-Up Child:

1. Name (print):_____Relationship to Child: _____Phone Number: _____
2. Name (print):_____Relationship to Child: _____Phone Number: _____
3. Name (print):_____Relationship to Child: _____Phone Number: _____
4. Name (print):_____Relationship to Child: _____Phone Number: _____

AUTHORIZATION FOR WALKERS

My Child has my permission to walk home from the program on the following days and times ***(NO TRANSPORTATION OR ESCORT SERVICE IS PROVIDED):***

Mondays: _____ Time Child Leaves: _____
Tuesdays: _____ Time Child Leaves: _____
Wednesdays: _____ Time Child Leaves: _____
Thursdays: _____ Time Child Leaves: _____
Fridays: _____ Time Child Leaves: _____

_____ _____
Parent/Guardian Signature **Date**

MEDICAL RELEASE FORM

Participant's Name (print): _____ Age: _____

Address: _____
Number Street City State Zip

Name of Child's Physician (print): **Physician's Phone Number:** **Insurance Company:** **Policy/Group Number:**
***** School: _____ Grade: _____ Age: _____
Date of Last Tetanus Shot (your child cannot attend program without this information):
Allergies (please list):
Is your son/daughter under the care of a physician for a medical problem? Yes ___ No ___ If yes, please explain: _____
Is your son/daughter taking medication prescribed by a physician? Yes ___ No ____ If yes, please list all medications: _____
Other information we should be aware of or any medical problems which may require special attention: _____
Are you exempt from any immunizations for religious or medical reasons? Yes ___ No ____
Do you have any religious objections to your child taking medications? Yes ___ No ____

*** If your child does not attend a State of Maryland School, you will need to provide a copy of your child's immunization records to the Recreation Department before the 1st day of the program.**

Health information - Are there any special needs, medical conditions, or behavioral conditions that we need to be aware?
Check any that apply and explain.

___ Good general health
___ Allergies (food, other)
___ Asthma
___ Diabetes
___ Other medication
___ Seizure
___ Behavior issues
___ Significant mental health condition
___ Prescription medication
___ Other chronic health condition (please explain)

Please explain:

_____

In the event of a **MEDICAL EMERGENCY**, I hereby grant permission to have(Child's Name):_____ taken to the nearest hospital to receive medical treatment.

_____ _____

Parent/Guardian Signature **Date**